

Page 33

1 support her mother with further breast
2 feeding, that I had discussed management with
3 Dr. Coleman, and that I had a very lengthy
4 discussion with her parents after the child
5 was back from her treatment room and her I.V.
6 fluids were now running. I had had -- that's
7 the time I had the long discussion with the
8 family.

9 Her first set of electrolytes
10 had come back. Her sodium was down a tiny
11 bit, which is exactly what you want, things to
12 go very, very slowly. And I explained to them
13 that she would get I.V. fluids, that we would
14 help mother pump her breast milk, feed it to
15 the baby by bottle so that she could see what
16 she was getting. That she would get both
17 breast milk, which was very important to
18 mother, plus I.V. fluids.

19 Both the medical needs and
20 social needs, provide emotional support and
21 medical care, the importance of the head
22 ultrasound. Talked to her primary care
23 physician, and discussed the long-term
24 consequences of her diagnosis, and sat down

Page 34

1 with her entire family in the room to explain
2 what this meant.

3 Q Okay. Why -- Strike that.

4 You have made a point here that
5 it was important that she be rehydrated
6 slowly; correct?

7 A That is correct.

8 Q And that is something you discussed with the
9 MGH and the neonatologist as well?

10 A That is correct.

11 Q And why is it important to rehydrate slowly?

12 A Because the -- you do not want the serum
13 sodium to rise too rapidly. So you want it to
14 rise over a 72 to 96 hours.

15 Q And why? Why is that?

16 A Because of intravascular fluid shifts.

17 Q The notion is you're trying to prevent
18 intravascular fluid shifts?

19 A You're trying to prevent rapid intravascular
20 fluid shifts, that's correct.

21 Q And if such fluid shifts occur, what are the
22 consequences?

23 A Medicine is not a black do A, B happens.

24 There are recommendations and guidelines. I

Page 35

1 followed the recommendation made in -- the
2 recommended therapy. The recommended therapy
3 is to treat slowly.

4 There are known risks. The
5 known risk of this condition is
6 intravascular -- an intravascular bleed or
7 thrombosis that can happen at any time during
8 this procedure, during the event. So that you
9 want to very carefully treat the patient to
10 minimize the risk, but your entire -- the
11 diagnosis in and of itself has placed you at
12 high risk for having some -- the said
13 condition happen to you. So your therapy
14 needs to be carefully tailored to minimize
15 your risk.

16 Q Is it the dehydration itself, the
17 hypernatremic dehydration, which puts you at
18 risk for the bleeding and thrombosis or is it
19 the rehydration process?

20 A The dehydration in and of itself puts you at
21 risk for having an intravascular bleed.

22 Q Okay. Does the dehydration itself create
23 these intravascular fluid shifts?

24 A The dehydration in and of itself creates a

Page 36

1 condition where your -- you have swelled. I
2 mean, this is akin to not feeding someone for
3 two weeks and then refeeding them. I mean,
4 this is a baby who was not fed for a week.

5 Q All right. But my question is, is it --
6 you're saying -- are you saying it's the
7 hypernatremia -- I'm using these terms
8 interchangeably, aren't I? I mean, we're
9 talking about hypernatremic dehydration;
10 correct?

11 A (No response.)

12 Q Correct?

13 A Yes.

14 Q All right. So --

15 A I guess my answer to your question --

16 MR. GREENBERG: I think the
17 question is, correct me if I'm wrong, Michael,
18 is Mr. Appel wants to know if it's the
19 hypernatremic dehydration in and of itself
20 that causes the intravascular bleed or whether
21 it's the fluid replacement that causes the
22 intravascular bleed. So if you can just
23 address that question, Doctor.

24 A My answer is I don't think that question can

Page 37

1 be answered because the -- both the -- both
2 things are intrinsically linked, and the
3 hypernatremic dehydration in and of itself has
4 stressed the child's blood vessel and stressed
5 the child. This is like leaving your house
6 plants with no water for two weeks.
7 MR. GREENBERG: Doctor, you
8 don't have to go by analogy. The question is
9 you're saying it's a combination of both or
10 you're saying that you're not able to answer
11 that particular question? Strike that. I
12 shouldn't be asking the questions here.
13 Mr. Appel -- why don't you
14 answer -- ask the questions.
15 If you don't understand the
16 question, Doctor, ask him to rephrase it for
17 you. Just answer the question.
18 Q All right.
19 A I don't -- my answer to the question is I
20 don't think I can answer the question.
21 Q All right. So -- If you don't mind, I'm going
22 to try to characterize this in lay terms. And
23 if I'm characterizing it inappropriately,
24 please tell me.

Page 38

1 Is what you're saying is that
2 once the child develops the condition of
3 hypernatremic dehydration, the child is at
4 risk for intravascular bleed and thromboses,
5 and that that can occur at any point once the
6 child develops the condition? It can happen
7 spontaneously or it can happen even during the
8 fluid replacement treatment; correct?
9 A What I'd like -- I'd like to repeat what
10 you've said. That when a child has been as
11 severely dehydrated as Estella and has lost as
12 much weight, the -- what happened to her brain
13 prior to arrival at Emerson Hospital in terms
14 of the amount of dehydration and amount of
15 fluid shift and shrinking in her brain prior
16 to arrival at Emerson Hospital puts her at
17 very high risk that, no matter how careful and
18 meticulous the fluid management is in
19 anybody's hands, the condition in and of
20 itself is very high risk. It is an
21 intrinsically high risk condition, like many
22 medical conditions are. They carry a certain
23 risk.
24 Q All right. What are the risks of rehydration

Page 39

1 at a rate that you would consider to be too
2 high? That is, you term the rehydration rate
3 as being deliberately done slowly here. And
4 is there a reason for that? I mean, what are
5 the consequences when it's not done slowly
6 enough?
7 MR. GREENBERG: I think she
8 answered that before.
9 But answer it again, Doctor.
10 MR. APPEL: Yeah.
11 A I don't -- I would like to answer the question
12 differently. What I would -- the question I
13 would like to answer --
14 MR. GREENBERG: No. No, Doctor,
15 please. Just answer Mr. Appel's question.
16 Q You just have --
17 MR. GREENBERG: The best you
18 can. Okay? Don't rephrase his question.
19 Answer it the best you can or ask him to
20 rephrase it if you can't answer it.
21 A Your question is what is the risk of doing the
22 therapy wrong.
23 MR. GREENBERG: No. What's the
24 risk of rehydrating too quickly. Just answer

Page 40

1 the question, Doctor.
2 A The risk of rehydrating too quickly are many,
3 but that's asking me to say what's the risk of
4 doing -- practicing medicine not in a careful
5 manner.
6 Q Well, --
7 MR. GREENBERG: Doctor, let's
8 take a break. Let's take a break. Okay?
9 Let's take a quick break.
10 (Attorney Greenberg and
11 witness confer outside
12 conference room)
13 MR. GREENBERG: Why don't you
14 try your question again.
15 MR. APPEL: Okay.
16 Q Let's see if I can rephrase it.
17 I take it there's a reason why
18 it was your decision to rehydrate slowly;
19 correct?
20 A Yep.
21 Q Okay. And you also discussed the rehydration
22 issue with the neonatologist at MGH?
23 A Um-hmm.
24 MR. GREENBERG: And I'm sorry,